Providers have placed a considerable priority on cash sales as reimbursement both from Medicare and private payor insurance has dropped. Moreover, retail has proven its worth to providers that have explored this important revenue opportunity. Not only are patients of all types willing to pay cash for the DME and related items that they want, but retail sales are free from Medicare hassles.

However, there is one key segment of the medical equipment market that all retail-minded HME provider businesses must truly target: seniors. Ten thousand people turn 65 every day, and the Pew Research Center says that trend will continue over the next 15 years. Also, data shows Baby Boomers outspend all other U.S. age groups on consumer items by $400 billion each year, and account for 55 percent of all consumer packaged goods transactions. Simply put, seniors have both the numbers and the money to be providers’ top target market.

So what do providers need to do in order to capitalize on the senior retail marketplace? This issue’s cover story interviews a number of the industry’s retail experts to get an idea of the senior market’s cash sales potential; how providers can reach them; and the sorts of products they should offer. What they have to say might surprise you!

Harnessing the Senior Retail Market . . . . . . . Page 17

Retail DME Has Grown Essential and With It, so Have Seniors

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Harnessing the Senior Retail Market . . . . . . . Page 17
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18 Money in the Bag

Providers are working overtime to drive new revenue, and retail sales comprise a critical element of that effort. Given their numbers and spending power, seniors represent a critical cash sales category for HME businesses. We interview industry experts to get top tips that can help providers expand their retail sales by targeting this important and growing demographic.

Legislative Update

33 New Ideas

The fight against competitive bidding has been a difficult one, and after several efforts to repeal or replace the program it’s becoming increasingly clear that the current strategy isn’t working. Now the industry has a new bill that fixes a critical flaw with the program: suicide bids. Better yet, unlike past efforts, this legislation has a solid chance of passing as a standalone bill.

Columns & Departments

News, Trends & Analysis

Legislation to fix audits unveiled; Binding bids bill launched; CMS announces Round Two re-compete; CMS proposes rule on taking bidding national; Great Lakes Home Medical Services Association debuts; Home Care Medical Enters contract with Dean Health Plan; Compliance Team expands patient satisfaction portal.

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An examination of how Medicare audits are affecting the oxygen industry and how respiratory providers are responding.

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Editor’s Note

Marching Orders

August offers a golden opportunity to fight bad policies on various fronts.

Today’s work environment is one fraught with constantly changing priorities and mounting to-do items that overwhelm a person’s calendar. It’s amazing that HME professionals can get anything done given how much they have to manage. Well, your workload just got bigger — but in a good way.

Are you sick to death of audits and competitive bidding? Good news: you have new ways that you can fight these policies, and August is the month in which you must wage that battle. Both the House and the Senate will be taking their recesses this month, which means your lawmakers from both chambers will be back in their home offices, taking meetings and working with their legislative staff.

So, the industry has cooked up two new bills (and possibly has two more as this issue goes to press) for fighting competitive bidding and CMS’s haywire audit system. Moreover, you have ways to respond to CMS’s plan to take competitive bidding national. Let’s review them one-by-one.

Binding Bids

If you turn our “News, Trends & Analysis” section (page 8) and our legislative feature “New Ideas” (page 33), you’ll see that the industry is shifting its strategy in the fight against competitive bidding. After many years, it’s becoming clear that trying to repeal or replace the program is not working.

So the industry has worked with champions Reps. Pat Tibbels (R-Ohio) and John Larson (D-Conn.) to introduce H.R. 4920, the binding bids bill, which would require all bidders to have a surety bond that would ensure they live up to their bid amounts and accept contracts for those amounts. It eliminates the biggest problem with competitive bidding: suicide bids by speculative bidders. Better yet, industry’s legislative leaders are working to introduce a Senate companion bill that should hopefully enter the docket by the time you read this.

This is critical legislation that many are saying is the industry’s best hope for getting relief, but it needs your support. Make sure to contact your Representative (and hopefully Senators) and get them to back this legislation. And if your Representative already backed H.R. 1717 (the MPP bill), then he or she is an easy convert to H.R. 4920, as it is one component of the broader MPP bill.

Audit Relief and Reform

For many providers, audits are an even bigger threat to their businesses than competitive bidding. We already know the system compensates auditors for finding errors, but overloads the appeals system because many of those errors are technicalities at worst. The system is unfair and unjust, and it needs massive reform.

To fight that, Reps. Renee Ellmers (R-N.C.) and John Barrow (D-Ga.), have released H.R. 5083, the Audit Improvement and Reform Act, which addresses many key problems with Medicare’s audit program. This is another bill that you can help back today. All you need to do is call. Need help shaping your argument? Well, the American Association for Homecare has launched FixMedicareAudits.org, a site designed to help providers advocate on behalf of the bill. (Read more about the bill and AAHomecare’s site, starting on page 8.) And, like the binding bids bill, you might see a Senate companion this month.

National Expansion

Lastly, you might recall that CMS made an advanced notice back in February that it was gearing up to take competitive bidding national by 2016. Well, the agency has released its proposed rule, and it is indeed planning to apply competitive bidding’s existing rates to non-bid areas by Jan. 1, 2016. In less than 18 months rural providers must provide DME to beneficiaries at suicide rates, with no way to build additional volume to compensate for the loss.

Now is the time to go to www.regulations.gov, read the proposed rule, and follow the “Submit a comment” instructions to respond. The deadline is Sept. 2. (Again, turn to “News, Trends & Analysis” for more detail.) Better yet, at press time the VGM Group was working on creating an online resource at that would help facilitate providers getting their response to CMS, so take advantage of that.

I know that you’re busy already. It’s hard enough running a company, especially under the crazy funding and regulatory environment that CMS has created. But as a smart HME professional, you also know that’s exactly why you need to take the time to advocate on these three agenda items. Your industry, your patients and your business depend on it.
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Legislation to Fix Audits Unveiled

Bill introduced by Rep. Ellmers and Barrow boosts transparency, rewards low error rates.

Representatives Renee Ellmers (R-N.C.) and John Barrow (D-Ga.), have released the Audit Improvement and Reform Act (aka, the AIR Act), a bill designed to address key problems with Medicare’s unchecked audit system by boosting transparency within the program; providing better education and outreach; and rewarding suppliers that have low error rates on audited claims.

“Thousands of small businesses across the country are facing complex and unnecessary burdens just so they can get compensated for the medical equipment they are providing for our seniors,” Rep. Ellmers said in a public statement. “This is happening because of an excessive auditing system enforced by the Department of Health and Human Services (HHS).”

The AIR Act, H.R. 5083, would apply to all MACs, RACs, and all other contractors performing audits on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers. Key provisions include:

- Providers will receive a score on their error rates. Suppliers with low errors rates will receive fewer audits.
- Providers with error rates of 15 percent or lower will only be subject to one random audit for the year they have a low error rate.
- Clinical inference and clinical judgment when evaluating audits is restored in the audit process.
- Look-back periods are limited to three years rather than five years for MACs and four years for RACs.
- MACs and RACs must provide quarterly training on avoiding frequent payment errors, including notice of all new audit procedures and education to avoid clerical errors. Funding for these programs will be derive from 25 percent of recouperments.
- Requiring the reporting of error rates on audited claims after adjustment for those audited claims that have been overturned on appeal.

The full text of the bill, as well as other issue-related information can be found at www.FixMedicareAudits.org, a site launched by the American Association for Homecare in support of the legislation. The site brings together the key components of AAHomecare audit reform strategy, including support for the AIR Act; the HME Audit KEY audit data collection and reporting platform; and Share Your Audit Story, a place to share stories of how audits have hurt patients and providers.

“This has been as unfair as it can possibly get,” said AAHomecare President Tom Ryan. “In an out of control process fueled rampant audits, and then the victims of these audits no longer had an appeals process to challenge the findings. We applaud Rep. Renee Ellmers (R-N.C.) John Barrow (D-Ga.) and other sponsors of the legislation for recognizing that something had to be done to protect the rights of providers across the country.”

“With her background as a nurse, Rep. Ellmers knows healthcare and she knows DME, said Jay Witter, vice president of government affairs for AAHomecare. “Rep. Ellmers has been an advocate for the HME industry, thanks to hard work from NCAMES and HME providers in North Carolina. These members built a relationship with Rep. Ellmers and educated her on the issues such as competitive bidding and the out of control audit system that hurts businesses.”

At press time, when the bill was only several days old, but it had already has six co-sponsors signed on —

Binding Bids Bill Unveiled

H.R. 4920 aims to correct key competitive bidding failings by making all bids binding and requiring surety bonds for bids.

Aiming to negate some of the most damaging elements of CMS’s competitive bidding program, Reps. Pat Tiberi (R-Ohio) and John Larson (D-Conn.) have introduced H.R. 4920, legislation that would make all bids binding, as well as require providers to obtain bonds before bidding.

The issue of competitive bidding operating on non-binding bids has long been cited as a major flaw in the program, because it lets companies engage in the sort of low-ball bidding at prices that some bidders have no intention of honoring. This has led so many longtime providers being bid out of categories of competitive bidding areas they had served, severe reimbursement cuts, and patients experiencing diminished access to care.

Titled the Medicare DMEPOS Competitive Bidding Improvement Act of 2014, the legislation would also require that providers put up surety bonds — “bidding bonds” — before submitting their bids to ensure those providers would truly bid an amount they could support. So, for example, if CMS offers a winning provider a contract and the provider declines to sign it, CMS can collect the bond. And when a provider wins a contract, the bid bond transfers to the performance bond that is already required.

“Reps. Tiberi and Rep. Larson have introduced this bill, which aims to be bipartisan, non-controversial, and budget neutral — the critical elements that legislation needs to be passed into law,” said Cara Bachenheimer, senior vice president for Government Relations at Invacare Corp. “If a bidder has a real financial stake when submitting bids, economists expect more responsible bidding to be submitted. The bill would insert a level of integrity and accountability into the bid program that simply doesn’t have it today.”

“When Congress tasked CMS with implementing a bidding program for home medical equipment, I don’t believe it was their intent to have it evolve into a bidding program that simply doesn’t have it today.”

With her background as a nurse, Rep. Ellmers knows healthcare and she knows DME, said Jay Witter, vice president of government affairs for AAHomecare. “Rep. Ellmers has been an advocate for the HME industry, thanks to hard work from NCAMES and HME providers in North Carolina. These members built a relationship with Rep. Ellmers and educated her on the issues such as competitive bidding and the out of control audit system that hurts businesses.”

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AAAHomecare Launches Audit Reform Site

FixMedicareAudits.org will provide online nexus for advocates looking to help reform of Medicare's audit program.

The American Association for Homecare has launched FixMedicareAudits.org, a new online portal designed to help the industry support Medicare audit reform efforts.

FixMedicareAudits.org will provide an single point online to help providers learn everything they need to know about audit reform and how to support H.R. 5083, the Audit Improvement and Reform (AIR) Act. The AIR Act.

“From a strategic standpoint, bringing together all of our resources and initiatives on this issue on a platform like FixMedicareAudits.org will help us educate policymakers, opinion leaders and the industry about the need for significant improvements for the Medicare audit process,” said AAAHomecare President and CEO Tom Ryan.

The site brings together the different components of AAAHomecare’s audit reform strategy including the HME Audit KEY audit data collection system, audit education resources and Share Your Audit Story, a platform to share how audits have hurt patients and providers.

Key site elements:

• Get the Facts About Medicare Audits. This site explains the basics about audits and how they impact access to care and the alphabet soup of auditors. AAAHomecare members can also learn how to get involved in changing audit policy through the association’s Regulatory Council and Audit Task Force.

• Audit Reform. The AIR Act. Here, providers can review the key provisions of the newly introduced Audit Improvement and Reform Act (AIR Act), H.R. 5083, including the issue brief, section by section and full bill text for more detail. Visitors can learn why they should support the bill and take action by sending an email to their elected official.

• The HME Audit Key. Using data to quantify the impact of audits on the industry and report compelling facts that policymakers cannot ignore is a cornerstone of AAAHomecare’s audit reform strategy. This initiative, called the HME Audit Key, is a new audit data collection and tracking system that will compile industry data on audits. HME stakeholders should join the growing list of companies who have pledged financial support for this massive undertaking that will benefit the entire industry.

• Share Your Audit Story: AAAHomecare is collecting stories about how audits have personally affected HME beneficiaries and providers. These stories will be used to help inform policymakers about the real problems with this program. AAAHomecare will use this information to continue to spread the word about challenges with audits with regulatory agencies, industry stakeholders and Congress.

CMS Proposes Rule on Taking Bidding National

After February advanced notice, CMS releases proposed rule, is soliciting comments.

After the Centers for Medicare & Medicaid Services sought public comment earlier this year in February regarding plans to expand competitive bidding nationally by 2016, it has now released a proposed rule for the plan.

The proposed rule, titled “Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies,” includes the methodology for making national price adjustments to payments for DMEPOS providers not in Rounds One or Two that would be paid under fee schedule.

A key problem with the proposed rule is that it would set rates for rural providers based on national bidding rates. Those providers would be put in the position of having much lower reimbursement, without any kind of volume increase to support the lost reimbursement. CMS is soliciting comments on various element of the proposed rule (linked above). To submit comments online, visit www.regulations.gov and follow the “Submit a comment” instructions. The deadline is Sept. 2.

Correction: The contact information for the Board of Certification and Accreditation (BOC) was incorrectly listed in the Resources Guide in our July Buyer’s Guide issue. The correct information is:

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Great Lakes Home Medical Services Association Debuts
New association merges advocacy assets of Indiana, Illinois and Michigan HME associations.

Three state HME associations have united in order to form a new association for the Great Lakes region. The leaders of the Association of Indiana Home Medical Equipment Services (AIHMES), the Illinois Association for Home Medical Equipment Services (IJAMES), and the Michigan Independent Providers Association (MIPA) coordinated a legal merger and have formed the Great Lakes Home Medical Services Association.

The decision was made to help the association continue to engaging in vital industry advocacy efforts for their regions despite shrinking resources. In fact, the three associations have had some experience uniting their advocacy efforts already. Last year after AIHMES, IJAMES and MIPA enjoyed a successful collaborative conference in Chicago. Based on that experience, the associations’ respective Boards of Directors decided to proceed with the legal formation of a regional organization. The respective memberships of each group completed the necessary voting process over the winter; the paperwork was filed this spring to form the merger; and the new association has recently received notice from each state’s respective Secretary of States that the merger is now final.

The new organization hosted its inaugural meeting pending the merger finalization at the 2014 HME Regional Conference and Exhibition “The Road to the Future Starts Here,” which was held May 20 and 21 in Tinley Park, Ill.

“We are excited about this regional development and believe this merger will strengthen our national voice, enhance our state focus and reenergize education and lobbying efforts during
this time of intense business consolidation and uncertainty,” stated Neidi Mack, formerly IAMES president, and the newly elected president of the Great Lakes association.

“There has been casual conversation about mergers within the HME association community in our states over the past several years as we’ve seen the issues escalate and the member companies consolidate. The controversial Medicare bid program has been difficult for everyone touched by the initiative and the time was right to take this action now,” states Kam Yuricich, executive director. “I’m thrilled to be working with such a resilient group of providers whose dedication to their profession and communities, and commitment to the HME industry at large, are tireless and visionary.”

All members of the three merging organizations were grandfathered into the new regional association. A campaign is currently underway to bring on new voting members as well as associate members and sponsor partners. The newly elected officers and Board members for Great Lakes represent a blend of organizations throughout the tri-state area, including President Neidi Mack, OSF Home Care Services (Illinois); Vice President Paula Koenig, Numotion (Indiana); and Treasurer Dave Doubek, Doubek Medical Supply (Illinois).

The association will be managed by Select Association Management, which has been managing IAMES and AHIMES over the past several years. Providers interested in voting or associate membership should contact Heidi Moss directly at the Great Lakes association at (614) 652-9925. Providers looking for more general information about the association should contact Kam Yuricich at (614) 652-9927.

Compliance Team Expands Patient Satisfaction Portal

Online benchmarking service will help providers prove their quality claims.

The Compliance Team (TCT) has expanded enrollment for its web-based patient satisfaction reporting and benchmarking service to include all DMEPOS provider organizations whether accredited by The Compliance Team or by another Medicare approved accreditation organization.

In her email Canally disclosed the rationale behind her decision to expand the reach of TCT’s proprietary satisfaction reporting and benchmarking service.

“The Compliance Team was the first nationally recognized healthcare accreditation organization to require the submission of patient satisfaction surveys on a quarterly basis going back to 1998,” wrote TCT Founder and President Sandra Canally, RN, in a company email. “This likely makes TCT’s database the oldest and largest of its kind.”

“Today, given Medicare’s and managed care’s emphasis on pay-for-performance and mandates for providers to prove their quality claims, we believe the time is right to expand our electronic benchmarking service to include all DMEPOS providers; not just those accredited by TCT,” she added.

The Compliance Team made patient satisfaction reporting an integral part of its accreditation process since launching its Exemplary Provider accreditation program for DMEPOS in 1998. To date, the firm has collected, aggregated and benchmarked over 1.3 million patient satisfaction surveys while garnering 10 million standardized data points from providers based in all 50 states, Puerto Rico and the US Virgin Islands, according to Canally.

Officially launched on July 12, the online benchmarking service’s introductory subscription fee for non-TCT accredited providers is $249/year for the first location. Multiple site DMEPOS businesses are priced on a sliding scale.

Enrollees are given on-line access to standardized DMEPOS questionnaires that are utilized to conduct follow-up patient satisfaction phone surveys. The results are then uploaded to The Compliance Team’s national database for aggregation and peer benchmarking.

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Funding Fundamentals

Avoiding the KX Modifier Trap

CMS will make the KX modifier a prominent tool in its anti-fraud arsenal.

I am going to use a metaphor to try and get my point across. The DME supplier is a harmless, little mouse simply trying to get a piece of cheese. That cheese is a reimbursed claim. Now, CMS is a homeowner trying to rid her house of these mice. So, she sets a trap for the mice with a piece of cheese; just want the mouse wants. The most important part of this metaphor is what that trap represents — the KX modifier.

The KX modifier is going to become a prominent tool in CMS’ arsenal to combat fraud, waste, and abuse. It’s an attestation you put on a claim for payment to the federal government. It is very serious. In most cases where the modifier applies, the policy states that, “Suppliers must add a KX modifier to [Procedure Code] only if all of the criteria in the ‘Indications and Limitations of Coverage and/or Medical Necessity’ section of this policy have been met.” In some cases, it also adds that evidence of such is kept in the supplier’s files.

The reality of the situation is that physicians do not know what those indications and limitations of coverage are unless we have educated them. Even if they do, that certainly doesn’t mean they have documented that clearly. Therefore, in a majority of cases, the documentation is not there to specifically address that the patient qualifies. One might be able to infer this information but that’s not what the attestation above states.

Understanding the Trap

Why is this a trap? Well, because the claim will not get paid unless a supplier uses this modifier. You will not receive reimbursement without it. Right now, in an audit situation, if you do not have the documentation to support the KX modifier, it will result in a claim denial or overpayment that you can fight through the administrative appeals process. I am of the opinion that CMS is leading us down a path that no one wants to go down. If a federal auditor requests documentation from you on a claim with a KX modifier and you either do not have it or it does not show the indications and limitation of coverage from the Local Coverage Determination have been met, they can reasonable accuse you of violating the Federal False Claims Act.

The False Claims Act makes it a federal crime for anyone knowingly presenting, or causing to be presented a false claim for payment or approval. The penalties for violating this Act can be severe. In these instances, they could easily result in Civil Monetary Penalties. The penalty for violating the False Claims Act is $11,000 per violation and/or three times the amount of the falsely claimed charges. Now, each line item on a submitted claim can be considered a violation. So, what if federal claims auditors requested a sample of 100 claims with KX modifiers? The penalties could quickly and easily exceed $1 million.

I think you see where I am going with this. I think our industry is very vulnerable. As a supportive outsider looking in, who also happens to be a Certified Fraud Examiner and Accredited Healthcare Fraud Examiner, I do not want to see this happen. I believe we must take some necessary steps to assure that we are using the modifier correctly, that our staff knows the importance of it, and that we are not putting ourselves and our business at risk for further scrutiny or penalties.

Some Homework for You

Everyone reading this article should go and audit at least 10 charts with KX modifiers. Pull up the LCD and go to the “Indications and/or Limitations of Coverage and/or Medical Necessity” section of that policy and review the criteria. Then, look at the clinical records. Hopefully you have them already in your file since that KX modifier was added, so someone must have checked that before appending the modifier.

Now, see if your clinical notes support that the criteria have been met. Do not make inferences in your review. Look through the documentation and see if you can determine with certainty that the documentation supports that this patient qualifies for the particular piece of equipment. Do not assume they do because you know the patient or their background.

Look at it from an auditor’s perspective: If you can’t definitively say you can prove that the criteria have been met, then you might have a difficult time defending a false claim violation in the future if they go down that path. Don’t get caught in this trap. Often times, the way CMS tried to deal with perceived fraud in a particular area is to implement more complex payment policies.

A great example here is with power mobility devices. There was a significant amount of fraud and abuse with these particular products. So, over the years, CMS implemented a much more comprehensive and complex policy that makes it difficult for anyone to qualify for reimbursement of these products. Then, they add a KX modifier requirement on these claims. You can see this pattern developing across many healthcare segments that CMS also sees as vulnerable to fraud and abuse, such as physical therapy and home health.

We must be diligent, proactive, and selective in submitting claims with a KX modifier. We should be requesting the documentation up front, reviewing it, and making sure that the documentation supports the criteria before making a decision to append that modifier to that claim. If the government moves forward with false claim violations, it could have devastating impact on our industry, so let’s work together to avoid that from happening.

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Wayne H. van Halem, CFE, AHFI is an author, consultant and President of The van Halem Group LLC (Atlanta, Ga.), a firm that helps HME providers navigate complex issues related to Medicare and Medicaid audits, appeals, and compliance. The van Halem Group recently become a part of the VGM Group Inc. He can be reached at wayne@vanhalemgroup.com.
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Problem Solvers

Asking the Right Questions

Patient satisfaction surveys are telling business tools.

CMS requires accredited providers to document patient satisfaction as part of their accreditation standards. If providers neglect to do so, it can cost them points on their accreditation score. But whether mandatory or not, collecting customer feedback is a business practice all providers should do in order to receive information that can improve their business.

When a provider is accredited, that means it needs to continue to meet or exceed CMS quality standards. Therefore, every accrediting organization (AO) has to have a standard that relates to a provider collecting patient satisfaction and complaint data from their customers.

CMS does not dictate measures to use to collect the data or what questions to ask patients. In fact, CMS basically looks for a pass/fail grade given by the provider's AO regarding the provider's overall patient satisfaction collection standards. Therefore, each AO is different in its proprietary standards of patient satisfaction data collection.

Sandy Canally, RN, President, The Compliance Team, a healthcare accreditation organization, says her company performs customer satisfaction benchmarking by having all their provider clients use the same tool to collect their customer satisfaction data. This funnels the information they convey regarding patient satisfaction into a database, where it is compared against thousands of other providers. Providers can then prove their ability by the benchmarked standard. Benchmarking also offers value-added feedback for improvement in this category.

Your AO and Customer Satisfaction

An AO must report customer complaints to CMS. Every month, Canally sends any patient complaints that her company has received against providers to CMS. Canally said that many of the complaints come from customers not being able to operate the equipment, which usually points toward the provider not going through the instructions thoroughly enough for the particular patient. There are also complaints about equipment not working properly and the provider not responding appropriately.

“If the provider has been contacted over and over again and it hasn’t been taken care of that’s when it elevates to the customer calling the accreditor,” said Canally.

Canally also pointed out that letting customer satisfaction data collection slide is probably an indicator of what’s going on currently in the provider’s business overall.

“If they look at customer satisfaction surveys from a business perspective, it’s in their best interest to track this because it’s going to help them identify things that perhaps they believe are occurring but can’t prove that they are occurring,” she said.

Informative Feedback

Patient satisfaction surveys can also help pinpoint where providers may be weak in certain business areas. For example, a provider sends a customer satisfaction survey out in the mail and receives a bad response that is not representative of its customer base. Canally’s team will look at that and give the provider recommendations to get a better response, such as instead of mailing a survey, make a phone call instead. In fact, the customer satisfaction collection database Canally uses with her providers lets providers call a customer, ask the eight questions and upload the responses into the database while still on the phone.

“Providers in our database have the capability to benchmark themselves against the thousands of providers in the database,” said Canally. A company with multiple locations can compare not just companies but different locations as well.

“What they then need to do is use that data in their business in a positive way, showing their customers, employees, referral sources and certainly the payers that its third-party accreditor is the one that aggregates and benchmarks this data,” she said. “That way a provider can say it’s been over 95 percent for the last six months against the national average. The benchmarking data can acts as a selling point for providers.

So what should be part of the survey? In the case of Canally’s Compliance team, to help providers that are part of its Exemplary Providers program achieve customer satisfaction per CMS standards and improve their business practices, The Compliance Team gives them eight questions to ask their customers regarding access, delivery and service. Those questions are:

- Did you feel confident to operate/use equipment/supplies?
- Were equipment/supplies ready for patient use upon delivery?
- Did you receive and understand instructions on proper application and use of equipment/supplies?
- Did you feel confident to operate/use equipment/supplies?
- Did you receive info on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company?
- Were responses to my questions, problems, or concerns addressed in a timely manner?
- Are you satisfied with the equipment or supplies?
- Are you satisfied with the service? Would you recommend us to others?

Mandatory or not, it is very important to the success of a provider’s business to understand the way a customer perceives the business, and customer satisfaction surveys open the door to that knowledge. Canally said feedback is key in any business to find out if:

- You are meeting the needs of your customers.
- You are using that information to positively grow your business.

“Every provider out there is looking for ways to survive and also take their business to the next level and grow it,” said Canally. “And customer satisfaction surveys are a way to give the provider a wake-up call about problems that they otherwise would not have noticed.”

Joseph Duffy is a freelance writer and marketing consultant, and a regular contributor to HME Business magazine and Respiratory & Sleep Management. He can be reached via e-mail at jduffy@hmemediagroup.com, or joe@profilerati.com.

Management Solutions | Technology | Products
Seniors represent a critical cash sales category for HME businesses. Industry experts share top tips to help providers expand their retail sales by targeting this growing demographic.

Senior cash sales? It’s money in the bag. With 10,000 seniors turning 65 every day, don’t ignore this booming sector. According to Pew Research center, about 10,000 people will turn 65 every day for about the next 15 years, making it an excellent time to target this growing market segment with a cash sales strategy. Other statistics, which were provided by VGM’s Retail team, that support a cash sales strategy for this demographic include:

- Baby boomers outspend other generations by an estimated $400 billion each year on consumer goods and services (U.S. Government Consumer Expenditure Survey).
- Baby Boomers account for nearly $230 billion, or 55 percent, of consumer packaged goods sales (Nielsen).
- In the next 10 years, U.S. baby boomers will increase their annual spending on wellness-based services from approximately $200M to $1 trillion (Paul Zane Pilzer, “The Next Trillion”).

To help you start or improve a senior retail strategy, here are top tips from industry retail experts:

- Invacare’s Mary Kander, Vice President, Lifestyle Products, and Chris LaPorte, Business Manager, Personal Care Products, says Invacare’s best selling products for seniors include bath safety items and walking aids. Having a “safe bathroom” vignette in a showroom shows seniors and their families all of the product options they can pursue to make sure the bathroom has the safety features needed to make the senior feel comfortable in the bathroom. The vignette also will show how to install,

By Joseph Duffy
“While initially seniors might be resistant to adding safety products to their bathroom, when they have an opportunity to see how the products would be placed in the bathroom and understand how they would be used, it’s much easier for them to understand the benefits and be comfortable with modifying their bathroom to incorporate these products,” says Kander.

With respect to walking aids, having a range of products in the showroom, including accessories, lets seniors try out different versions and styles to decide what suits them best.

“A senior who expects to be walking outside likely will choose a product that can better accommodate uneven surfaces than one who expects to use the walking aid mostly indoors where surfaces are more even.” Says LaPorte. “They may have preferences for transport (light-weight) and low storage profile. In addition, people who expect to use the walking aid for longer distances or periods of time likely would prefer a version that includes a seat. Having the accessories readily available provides the senior with the opportunity to better understand how products might provide additional benefits, such as a tray for carrying food or a pouch for carrying/storing personal items.”

Since most seniors want to stay in their homes as long as possible, providing them, and their family/caregivers with options to keep them safe in their home lets them stay there, says Kander. For the senior’s family, they are more willing to accommodate their loved one’s wishes if they know that the environment has been adapted to make it safe for them to continue to live in their home.

Sydel Howell is an HME provider with a retail store in San Diego. During the dawn of caps, cuts and Medicare reimbursement becoming less reliable, she set out to make her store independent of Medicare. Today she has contracts with HMOs for only two items and the rest are cash sales only. About 60% of her sales are

### Senior Retail Categories: The Obvious and the Not-so-Obvious

**When** looking at senior retail, one of the first things a provider will consider is what product categories are the right fit. The short answer is that there are many. In fact, nearly everything that providers currently offer seniors should be available as a cash sales item.

True, many seniors live on fixed income, but many do not. Some seniors have engaged in retirement planning that has allowed them to enjoy the finer things in life, including retail DME. Moreover, those seniors that are on fixed incomes often have children and other family members who are ready, willing and able to help foot the bill for retail medical equipment and related items.

Once providers integrate those two realities into their retail plans, it becomes glaringly clear that there is a whole world of retail items available to offer seniors. Let’s look at some obvious categories first:

**Daily Living Aids.** This is the old friend of retail HME. Many providers are well versed in this broad category of items that simply make life easier for patients and help them maintain their independence. The VGM Retail team (Rob Baumhover, general director; Maria Markusen, director of operations and development; Nicole Hontzik, director of merchandising and stores, Chris Thompson, creative director; Rachel Harris, account manager; and Staci Langel, customer service) gives several examples of these products.

- **Reachers**
- **Magnifiers**
- **Talking aids**
- **Low vision, hearing impaired phones**
- **Large display and bed vibrating alarm clocks**

**Incontinence.** Like ADLs, incontinence products are a clear stand-by when it comes to senior retail. Many seniors suffer from incontinence conditions, and feel stigmatized and embarrassed as a result. Providers that can offer a supportive, knowledgeable, and discrete incontinence supply business for them will beat out a big box retail any day — regardless of price.

**Compression.** Another clearly important senior cash category is compression. Many seniors need compression in order to increase circulation to improve circulation or to prevent or treat wounds. (This is especially true for diabetes patients.) But compression doesn’t just stop at wraps, hosiery and garments. There are special donning and doffing devices to help seniors put on and take off heavier compression items. Also, if a patient is wrapped as part of his or her treatment, cast bags for showering are an excellent item. Given that nearly all compression needs...
Respiratory & Sleep Management
Solutions for HME Professionals

Under the Microscope
How oxygen providers are responding to Medicare audits.

Also Inside:
• Second Quarter Sleep Market Survey
• Oxygen Conserving Device Round-up
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like most HME businesses, oxygen providers are concerned about the frequency of audits hitting their sector of the industry and the high error rates involved. Oxygen providers have some unique concerns, as recent CMS actions, such as the delay in assigning ALJs to audit appeals by two years, could hit oxygen providers particularly hard. Kim Brummett, vice president of Regulatory Affairs, American Association for Homecare, runs an audit task force made up of providers, manufacturers and industry consultants who meet every other month.

“We have been working closely with Congresswoman Rene Ellmers on legislative language that will address audit reform,” Brummett says. “The industry is concerned with the repetitive nature of the audits and when looking at patient new starts on respiratory therapy, the percent audited can be overwhelming. In addition, due to the repetitive nature of our patient claims, the volume of claims that we submit and then that hit the appeals process is overwhelming.”

But before Congress and industry crusaders such as AAHomecare can bring relief to businesses under fire, HME oxygen providers need to understand how audits affect their particular sector of the industry and what they need to do to prepare and survive audits.

Kelly Riley, CRT, RCP, Director, Clinical Networks, The MED Group, feels the biggest concern of the HME industry has been consistent for several months: the large number of audits, also known as additional documentation requests (ADRs), that the HMEs are receiving.

“While the payment for rental products has been drastically reduced, due in many cases to competitive bidding, the cost to respond to these audits is growing,” she says. “Many HMEs have replaced employees that previously held clinical care positions with employees who are more clerical and who are completing administrative tasks (i.e. retrieving paper records, answering questions of patients and healthcare professionals, validating existing data, etc.) to secure the needed information to comply with requirements.

“The removal of clinical inference has also had a negative impact,” she continues. “Previously, a nurse manager with the DME/MAC could review the medical record and clearly see a medical need existed. Today, claims are denied often due to technical errors.”

When it comes to audits and how they affect oxygen providers, Riley said that long-term oxygen therapy (LTOT), along with increasing ambulation and activity, to date, are the only two known interventions that are proven to have a positive impact on the effects of patients diagnosed with COPD.

According to the Medicare LCD for oxygen, the patient record must indicate that the COPD has progressed to a severe state in order for LTOT to be a covered service. Patients who are ordered supplemental oxygen are often some of the sickest patients the HME will provide services for, Brummett explains. When claims are denied and monies recouped, the HME is often forced into a challenging situation of deciding how long they can continue to provide the service to a Medicare beneficiary for free when they have ongoing costs that have to be covered.

What concerns Jeff Mastej, director of Compliance, Audit and Reimbursement for Detroit respiratory provider Wright & Filippis, the most about audits specific to oxygen is the urgency required for discharge purposes in concert with the detailed medical record documentation requirements to satisfy the Oxygen LCD prior to delivery.

“We have care, treatment and service standards which we have to maintain as an oxygen provider,” he says. “Our referrals have the expectation of immediacy. It’s a difficult balance to meet patient and referral source needs and all of the qualification information necessary to satisfy medical policy.”

Mastej said his company sometimes has to delay its service window (which is for all intent and purposes immediate) for hospital discharges.

“When you have to obtain dispensing prescriptions, oxygen testing results within specific parameters, physician notes which support the testing and the specific parameters and Certificates of Medical Necessity, the only success agent is communication and education,” he says. “You have to quickly identify who your partners in care are. You have to continually education referrals where you have difficulty securing the important qualification information. Service decisions may arise with specific referral sources where you have difficulty obtaining all qualifying information.”

**Nitpicking or Medical Necessity?**

According to Ronda Buhrmester, Reimbursement Specialist for VGM Group Inc., today’s audits seem to be based more on technical denials rather than medical necessity.

“Suppliers are starting to really doubt themselves when receiving a
Under Medicare’s Microscope

“While the payment for rental products has been drastically reduced, due in many cases to competitive bidding, the cost to respond to these audits is growing.”

— Kelly Riley, CRT, RCP, The MED Group

referral for an oxygen patient,” she says. “All suppliers want to do is take care of that patient and meet their medical needs so the quality of life can continue in the home setting. When oxygen suppliers know they have the medical necessity met for the oxygen referral, they now need to make sure all the i’s are dotted and t’s are crossed, documents are legible, etc., to supply home oxygen to a patient.”

For the oxygen industry, Buhrmester says the most recent concern is the face-to-face ruling under the ACA 6407, which was implemented July 1, 2013. While the stationary unit E1390, portable concentrator E1392, and home-filling unit K0738 are not part of the face-to-face ruling, other oxygen equipment is included, such as the portable system, E0431, oxygen content, E0443, liquid oxygen, and some other oxygen HCPCS codes. She notes that with the face-to-face ruling, both the detailed written order and face-to-face evaluation have to be in the suppliers’ hands prior to delivery of the equipment. The detailed order must have been written within six months of the face-to-face evaluation.

“Our referrals have the expectation of immediacy. It's a difficult balance to meet patient and referral source needs and all of the qualification information necessary to satisfy medical policy.”

— Jeff Mastej, Wright & Filippis

“Where this is a problem for oxygen suppliers and hospitals is upon discharge from a hospital setting,” Buhrmester explains. “If a patient needs a stationary concentrator and portable gaseous system to be discharged home, the portable gaseous system requires a written order prior to delivery, which means the supplier cannot deliver the portable system for the patient to be discharged to their home until the written order is received prior to delivery.

“We all know how busy life is in a hospital setting when they’re trying to get patients discharged home,” she continues. “Normally oxygen suppliers receive a prescription that states ‘2lpm home oxygen and portable with supplies.’ This type of order isn’t considered a written order prior to delivery because it’s not detailed enough.”

Buhrmester said that while the supplier can deliver the stationary unit based on that type of referral, the portable cannot be delivered until there is a written order prior to delivery in the DME suppliers’ possession.

“The patient needs the portable to get home because without the oxygen, their oxygen saturations will drop,” she said. “The supplier, then, has to get the written order completed by the practitioner prior to delivery.”

On May 29, CMS issued a release stating the treating practitioner does not need to be the prescriber of the order for the DME item. However, the prescriber must have knowledge and documentation of the face-to-face exam that was conducted. This clarification, Buhrmester explains, should help with the hospital discharges. Suppliers need to make sure there is communication between the treating practitioner, the prescriber, patient, and themselves.

In the same release, it states that RAC, ZPIC, DME MACs, and other program safeguard contractors cannot actively audit on the face-to-face evaluation requirement until “a date” in 2014. The WOPD started to be actively audited on Jan. 1, by the DME MACs. This delay in enforcement does not apply to the CERT auditors.

According to Buhrmester, with oxygen equipment, they are mostly seeing audits on the stationary concentrator, E1390, and the portable system, E0431, as well as the liquid oxygen equipment. These are prepayment results and are mix of oxygen equipment.

How to survive audits

Our article experts give their best tips to oxygen providers on surviving audits.

Jeff Mastej, director of Compliance, Audit and Reimbursement, Wright & Filippis:

• Ensure all staff (intake, clinical and delivery) are well versed in all LCD requirements.
• Revise (or establish) policy and procedure for oxygen services provided to Medicare beneficiaries.
• Share Dr./physician letters with your physicians and referral sources.
• Assure all qualification documents align; valid testing, physician chart notes and values populated on to your CMN and Detailed Written Orders.
• Internal audit (what gets measured is a key component of what gets managed in your facilities).
• Establish audit staff by job description; have staff members in place to immediately respond to audits.

Kelly Riley, CRT, RCP, director of Clinical Networks for The MED Group:

• Know which referral sources are going to work with you, to ensure you will be paid so that the HME can continue to provide products and services.
• Get all medical necessity documents prior to delivery of product.
• Obtain or create easy to understand tools to assist in education of referral sources.
• Perform “mock audits” at your company. Know what to look for in the medical record. Just because the patient saw the doctor within the designated time frame does not prove that the need for the oxygen was even discussed or entered into the patient’s medical record.
• Being willing to say “no.” A referral who will not provide the documentation to prove medical necessity for oxygen is a referral you can do without.

Ronda Buhrmester, Reimbursement Specialist for the VGAM Group Inc.:

• Educate and have communication among staff and referral sources, and even the patients. Use the documentation checklists that are available and use the quarterly results that each jurisdiction releases on the listservs as educational tools.
• Have a strong intake or customer service staff that understands the medical policies and is not afraid to ask questions. When the medical records are received, make sure to read the information to ensure that coverage has been met.
• Make sure to perform internal audits on a regular basis to make sure you are compliant with the medical policy and its requirements. It’s also a good idea to have external audits performed. This means to bring in an outside source/consultant to perform the audit to ensure compliance.
• Have desk procedures and make sure they are followed; compliance plans are important.
• Keep files in order with correct paperwork, legible signatures or use signature log; watch the dates.

Wayne H. van Halem, president of The van Halem Group:

• Implement a compliance program.
• Conduct internal audits.
• Request and review documentation for all equipment.
• Track and record all audits and outcomes to identify weaknesses.
• Educate and regularly train employees and referral sources on coverage policies.
• Sign up for all contractor listservs to stay on top of widespread issues and problems.

Kim Brummett, vice president Regulatory Affairs, American Association for Homecare

• Know all of clarified regulations and requirements.
• Teach all operational and sales staff the details of the requirements.
• Evaluate each patient with a critical eye.
• Set patients up correctly; either they meet criteria or they don’t.
• Get ABNs when appropriate and hold patients accountable financially.
Brummett says that the repetitive nature of rental claims makes it very challenging in the audit process. Due to timely filing limitations, suppliers continue to submit claims that they know will be denied and need to be appealed.

“This is really a very big issue,” she says. “In addition, the volumes of clarifications to the oxygen LCD have been onerous to say the least. It seems to be the most analyzed LCD. I do believe the days of incredible scrutiny on oxygen are beginning to back off. The MAC prepay audit quarterly denial rates indicate that oxygen denials are actually significantly lower than other product categories being audited.”

**ALJs Audit Appeal Delays**

A recent letter from Nancy Griswold, the chief judge of CMS’ Office of Medicare Hearings and Appeals (OMHA), said there was going to be a delay assigning an Administrative Law Judge (ALJ) to any new appeals for two years. The reason cited was a backlog of 357,000 claim appeals stacked up in the system that were pushing the current turnaround time for an appeal to 16 months.

“The delay is significant,” said Wayne H. van Halem, President, The van Halem Group. “Once it gets assigned, it could be another year or two before a hearing is scheduled. If a supplier undergoes a large audit and has a high volume of denied claims or a significant overpayment identified, then it could cause cash flow issues for suppliers who will have to wait to get paid or have to refund the money while waiting for a hearing. Recently, we’ve heard of an increase in ALJ cases getting dismissed for reasons we’ve never seen before. I’m afraid they are going to start dismissing cases citing Code of Federal Regulations (CFR) citations that have never been referenced or enforced before in an effort to reduce the workload. The ironic thing is that when they do this, it’s usually well after the 90-day deadline specified in the CFR, so they hold you accountable to one section of the CFR while blatantly violating another.”

As a result of the delay, Riley said HMEs need to protect their financial stability by not dispensing product until the documentation is in hand.

“Gone are the days when the intake process consisted of patient name, liter flow, duration of use, and SpO2 or PaO2 level,” she said. “Now the HME must ensure the patient evaluation (face to face) speaks succinctly to the reason for oxygen, as well as what other therapies have already been employed. They must also ensure that the patient is not being concurrently treated with positive airway pressure (CPAP/Bi-level) for OSA and that qualifying testing was done within the guidelines.”

Brummett called the ALJ delay “a very big deal for oxygen providers.” Since the services provided are reoccurring, suppliers have to submit claims every month, even if they know they will be denied because the first month was pulled in a pre-pay audit, she said.

“The issue is the limitation on timely filing for claims,” Brummett said. “Since suppliers never know when the first claim will be overturned, they can’t risk not submitting subsequent claims. The ALJ delay simply compounds the problem for suppliers. AAH has been working with CMS to implement an exception for this situation that not only would be good for suppliers and contractors, but it would also prevent the coverage criteria is met, ultimately submitting a clean claim the first time. Be proactive rather than reactive; implementing processes, not making projects. Following the medical policies, knowing the types of denials being reviewed, education of staff AND referral sources as well as understanding the processes are what will enable suppliers to remain in business.

van Halem said that without a doubt, providers must implement some proactive internal controls to assure claims get paid up front. A frustrating statistic from the results of the most recent widespread review was that 57 percent of the denials were for missing documents, such as the initial evaluation, the test results, or the delivery ticket or due to an incomplete or missing Certificate of Medical Necessity.

**“The industry is concerned with the repetitive nature of the audits and when looking at patient new starts on respiratory therapy, the percent audited can be overwhelming.”**

— Kim Brummett, American Association for Homecare

**“Suppliers are starting to really doubt themselves when receiving a referral for an oxygen patient.”**

— Ronda Buhrmester, VGM Group Inc.
When looking at the sleep market over both the recent past and the near future, it’s clear to see that sleep providers are in some ways having to relearn a market they used to know like the backs of their hands. They expect volume growth, but feel there are factors hindering that growth. Meanwhile, they’re coming up with ways to drive more revenue from the business to fight reimbursement cuts.

According to the Q2 2014 HME Sleep Survey conducted by HMEB’s Respiratory & Sleep Management and Needham & Company, sleep patient volume growth is expected to increase while product prices have continued to decline because of competitive bidding.

**Sleep patient volume growth**

Survey respondents on average reported seeing their sleep patient volume grow by 2.8 percent in the last 12 months and predict that their sleep patient volume will grow by 7 percent in the next 12 months. Of the respondents, 25 percent reported a decline in their sleep patient volume in the last 12 months and 16 percent expect a decline in the next 12 months.

- Automated calls (used by 42 percent of respondents)
- Email (used by 27 percent of respondents)
- Regular mail (used by 22 percent of respondents)

Respondents expect Medicare’s new resupply policy change to be an impediment to growth. On average, respondents report having seen a 6.6 percent reduction to Medicare sleep resupply sales versus a 2.4 percent reduction reported in the 4Q13 HME Sleep Survey.

This translates into an estimated 1.7 percent reduction in U.S. mask and accessory market growth, but 81 percent of respondents expect other insurers to copy Medicare’s new resupply policies, so the overall impact could increase going forward, the survey explains.

At what rate has your firm’s sleep therapy patient volume grown in the past 12 months?

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As the U.S. economy continues its recovery, respondents say they believe that the economy is barely creating a drag on their sleep patient volume growth. On average, respondents expect the domestic economy to reduce their sleep revenue by 0.1 percent over the next 12 months, according to the survey.

**Resupply Sales**

To drive resupply sales, 82 percent of respondents said that they actively follow-up with their sleep patients. The most common methods for follow-up include:

- Live phone calls (used by 70 percent of respondents)
- Automated calls (used by 42 percent of respondents)
- Email (used by 27 percent of respondents)
- Regular mail (used by 22 percent of respondents)

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This translates into an estimated 1.7 percent reduction in U.S. mask and accessory market growth, but 81 percent of respondents expect other insurers to copy Medicare’s new resupply policies, so the overall impact could increase going forward, the survey explains.

At what rate do you expect your firm’s sleep therapy patient volume to grow in the next 12 months?

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</table>

There is also an expectation that mask use will increase. Respondents said that patients used an average of 1.88 masks per year in the last 12 months and expect that use to climb to 1.97 masks per year over the next 12 months.

This could increase mask market growth by 4 percent to 5 percent, but as patients are now using almost two masks per year, the effect of increased replacement rates is probably slightly diminishing since we estimate this measure will max out at around 2.5 masks per year. (That’s based on two masks per year for privately insured patients x 75 percent of payer mix + four masks per year for Medicare patients x 25 percent of payer mix = 2.5 masks per year.)

**Round Two Bid Winners**

Of all survey respondents, only 9 percent said their company won a bid during competitive bidding Round Two, which is down from 20 percent in the Q413 HME Survey. Of those respondents that won bids, the most popular strategy to offset reimbursement declines is to negotiate lower prices with CPAP manufacturers. And this strategy seems to be having some success, as the respondents indicated that all three of the major manufacturers had reduced prices in the last three months in response to bidding.
Using a scale of 1 (very unimportant) to 7 (very important), respondents were asked to rate the following strategies for dealing with lower reimbursement in Round Two:

- Giving Medicare patients less featured (lower cost) CPAPs/masks from existing manufacturers (3.6 average score)
- Switching to lower-priced CPAP manufactures (3.5 average score)
- Giving Medicare patients less featured (lower cost) CPAPs/masks from new manufacturers (3.3 average score)

Respondents also said that commercial insurers have reduced reimbursement as a result of competitive bidding. On average, respondents reported seeing 13 percent of insurers respond with reimbursement cuts.

This corroborates anecdotal reports that private insurers have been cutting reimbursement rates, according to the survey.

A majority of respondents (60 percent) also indicated that they have been able to identify Medicare sleep patients that were previously being serviced by HMEs that did not win round two contracts.

While the survey did not ask how they have obtained this information, it is possible that HMEs that lost have been providing patient lists to the HMEs that won contracts, the survey reports.

### Auto-setting and Bi-level Flow Generators

According to respondents, 40 percent of their patients use auto-setting flow generators, which will likely grow to about 41 percent of patients over the next 12 months. Auto-setting flow generators sell for a premium to standard flow generators and can drive positive or negative mix shifts.

**Survey respondents said that 11 percent of patients use bi-level flow generators, which looks likely to increase to 13 percent of patients over the next 12 months. Bi-level flow generators also sell for a premium to standard flow generators and as a result we expect increasing use to drive a positive mix shift.**

### Flow Generator Price Declines

One thing the survey shows definitively is that flow generator price declines are, again, the worst in the history of our survey.

Respondents indicate that flow generator prices declined by 5.4 percent in the last 12 months versus a 3.6 percent decline in the 4Q13 HME Survey. This represents the largest decline seen in any of these surveys over the past eight years and indicates that flow generator price declines have worsened from prior surveys, most likely as a result of competitive bidding.

Suffice it to say that providers have as many questions about the sleep market as they have answers for our recent survey. Without a doubt the market has seen some game changing impacts from factors such as competitive bidding and the economic recovery, but the growth potential of multitudes of yet-to-be-diagnosed OSA patients makes it clear the market potential and growth are there — and providers are shaping new strategies to tap into it.

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**Joseph Duffy** is a freelance writer and marketing consultant, and a regular contributor to HME Business and Respiratory & Sleep Management. He can be reached via e-mail at jduffy@hmemediagroup.com or joe@proofrati.com.
Oxygen Conservers

Conserving devices can improve oxygen therapy; here are some recent offerings:

Oxygen conserving devices (OCDs) help make oxygen therapy more efficient, more portable and less intrusive. And, although they aren’t a solution for every patient, they can help improve therapy while also creating business efficiencies for providers.

OCDs control the flow of oxygen from the oxygen source to the patient. The OCD releases oxygen only when the patient inhales, which dramatically increases the amount of time a patient can use the oxygen supply. This offers patients increased mobility and comfort from avoiding a continuous flow of oxygen into the nostrils.

The two types of oxygen conserving devices are:

1. The fixed-pulse type delivers a pre-determined pulse (volume) of oxygen when the patient initiates a breath. The oxygen flow stops at a preset limit. These devices typically have higher initial flow rates, which determine the shape and size of the waveform and let the pulsed volume of gas be delivered in the first portion of the inspiration. The actual pulse volume of oxygen delivered per setting vary by manufacturer and specific device and are commonly based on mathematical models and assumptions intended to produce a fraction of inspired oxygen (FiO2) similar to that delivered with continuous flow.

According to Thomas L. Petty, M.D., Chair of the National Lung Health Education Program, pulse devices share these characteristics:

- They deliver fixed volumes for each flow setting each time a pulse is triggered.
- They do not deliver any more or less volume as the length of the patient’s inspiration time varies.
- They tend to deliver less than prescribed of oxygen per minute volume at low breath rates but can deliver more at high breath rates, e.g., during exercise.
- They tend to require more patient attention to conservator function to permit manually switching from conserver mode to continuous flow in case of conserver malfunction.

2. Demand-pulse units operate on the same principle as fixed pulse, in which a patient breath triggers the device to deliver the oxygen. However, depending on the specific device design, after the initial pulse of oxygen is delivered, some devices continue to deliver a preset flow (i.e., 2 liters/min) of oxygen until exhalation, while others have a diminishing flow until the valve closes and flow completely stops. How much of the oxygen flowing after the pulse is delivered in the first two-thirds of the breath depends on the device. Flow delivered in the last one-third of the breath is considered wasted, since it falls into the portion of the breath considered anatomical dead space.

According to Petty, demand devices share these characteristics:

- Following the initial bolus they deliver at the equivalent flow rate of continuous flow for the remainder of the inspiration.
- They deliver a variable volume at each flow setting depending on the length of inspiration.
- They have lower levels of savings at low breath rates but at a given setting can save as much as or more than pulse devices at high breath rates and high I.E. ratios.
- They tend to deliver volumes equal to or greater than those received with continuous flow therapy for most settings.
- They generally revert automatically to continuous flow without patient interaction in the event of conserver malfunction.

OCD manufacturers say the devices help providers by reducing the frequency of refills, cylinders and deliveries, thus improving their bottom lines.

No one device fits all patients’ needs; therefore, it can take diligent evaluation to find what works best for each patient. Here are some OCD offerings currently on the market:

**Oxygen Conservers**

**By Joseph Duffy**

**inovo AccuPulse Single Lumen Pneumatic Conserv**

The inovo AccuPulse Single Lumen Pneumatic Conserv operates quietly and has a 51 conserving ratio at every setting. The AccuPulse provides more oxygen when patients need it with a uniform pulse with every breath up to 40 breaths per minute, matching dose to patient need. Controls are easy to read and operate, giving patients less of a chance of accidentally switching to continuous flow. The unit comes with a three-year warranty, is lightweight and compact, and features six conserves and three continuous flow settings on a single control dial.

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**CHAD Evolution Motion Auto-Adjusting Oxygen Conserv**

The 14.9 ounce Evolution Motion Auto-Adjusting Oxygen Conservs sees patient motion and activity levels, and adjusts to preset rest and activity dose settings automatically and efficiently. Auto-adjusting conservs optimize both patient saturation and oxygen conservation. This product will match oxygen dose to patient need as defined by motion and activity. This unit can help decrease your delivery costs. The auto shut-off feature lets the Evolution Motion provide a one-year battery life using two standard AA batteries.

**Drive Medical Design & Mfg.**

(877) 224-0946

www.drivemedical.com

**Invacare Element Pneumatic Oxygen Conserv**

The Element Pneumatic Oxygen Conserv consists of a cylinder connection, cylinder contents gauge (if equipped), high-to-low-pressure regulator, orifice plate and a conserving demand module. The regulator reduces the high pressure of the cylinder to the working pressure of the orifice plate. The flow is determined by setting the flow control knob to the prescribed flow, and the oxygen is supplied to the patient through the cannula. Features include compact design, CGA570 compatible, no batteries required, single selector knob controls ON/OFF, liter flow and continuous flow mode.

**Invacare Corp.**

(800) 333-6800

www.invacare.com

**SmartDose Mini Electronic Oxygen Conserv**

The SmartDose Mini CTDOX-MN20 is an auto-adjusting electronic conserver that continuously monitors breath rate and adjusts the oxygen dose to match activity at every breath. During activity, the SmartDose will increase the preset rest setting up by as much as to two settings to match the dose to patient need. The SmartDose offers equivalent liter flows from 1-5, a minimum battery life of up to one year with two AA batteries, and an operating pressure from 500 – 3000 PSI. The unit weighs less than 16 ounces with batteries and its auto-adjusting conservers optimize both patient saturation and maximizing conservation.

**Drive Medical Design & Mfg.**

(877) 224-0946

www.drivemedical.com

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Stand Up for Homecare

The Stand Up for Homecare reception at Medtrade is the premier networking event for the homecare industry. When you Stand Up for Homecare, you are endorsing AAHomecare efforts to promote a positive image of the home medical equipment industry, raise public awareness of homecare’s many benefits, and support consumer advocacy groups out there making a difference in patient’s lives. It’s time for us all to stand together and support our industry, and have fun doing it!

AAHomecare.org/advocacy/stand-up-for-homecare

Atlanta, GA
October 21
6:00pm
Money in the Bag

Continued from Page 18

from seniors. The rest are customers sent by doctors for compression garments, post-mastectomy products or other caregivers.

She didn’t bid during San Diego’s competitive bidding process and stopped billing Medicare in August 2012.

“I knew that in 12 months I wasn’t going to be able to take care of those patients and I didn’t want to have to grandfather and deal with Medicare not paying me even though they say they would grandfather,” she says. “I didn’t trust them so I was done.”

“Our job is to educate. When people trust you and they know you are going to give them exactly what they need, they keep coming back. And they will tell their friends. And that’s how we became successful: high-quality products and high-quality service.”

— Sydel Howell, San Diego Homecare Supplies

Senior Retail Categories

are unfunded, this makes it an important retail offering for seniors.

Lift chairs. Lift chairs are another obvious retail item for senior patients, who often find it difficult to get into and out of chairs. Lift chairs come in a wide variety of styles and fabrics. Many incorporate different ranges of user controls, structural features and levels of support.

Diabetes. This is a key category given that so many seniors suffer from diabetes, and that there are a huge range of products that help seniors, from actual care management products to products aimed at treating co-morbidities and related conditions. The VGM Retail team suggests these items:

• Books and reference materials
• Diabetes management apps and software
• Sugar-free candy/foods
• Protein shakes and bars
• Food scales, portion control plates
• Diabetic cook books
• Weight loss books, apps
• Wound care
• Compression
• Diabetic I.D. Card, car visor, jewelry
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Howell's retail strategy is to provide high-quality customer service and high-quality products and she says she couldn't do that at the rates Medicare wanted to pay her.

Since this transition, Howell says her business has become better and more profitable.

"The same people who walk through the door and want something through Medicare come back the same day or within a week and buy it from me because they can't get it or if their insurance won't cover it or if it's taking too long to get approval," Howell says.

"Seniors are simply getting older. This does not make them automatically sick. They want items that will aid in their ability to live an independent life."

— Doug Francis, Drive Medical

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Howell’s store is 2500-square feet with three spacious fitting rooms. Each fitting room can accommodate a wheelchair, the patient and a caregiver. The rooms are big and comfortable so people can feel like
Money in the Bag

“We need to take a lesson from the big department stores and provide seniors with an experience. Starting with the way we greet them and not just let them wander throughout our store. Engage them, educate them, and sell them what they need and not what is on special.”

— Ty Bello, Team@Work

they are at home, says Howell.

“Our job is to educate,” she says. “When people trust you and they know you are going to give them exactly what they need, they keep coming back. And they will tell their friends. And that’s how we became successful: high-quality products and high-quality service.”

Another successful strategy Howell uses is she tells a story.

“When you walk into Nordstrom’s ladies department you see a mannequin wearing the clothes that are displayed in front of you,” she says. “All the jeans are together, all the shirts are together, the casuals together and the formals are together. It may have a splash of jewelry. You are telling a story about how things work together. So when somebody comes in for a cushion, they are also going to see other items that will go with that type of product. When people walk into your store, don’t make them feel lost. It needs to make sense why you group items together.”

Doug Francis, Principal and Founder, Drive Medical, says that the look and feel of storefronts are important but so is the actual customer experience.

“Consumers aren’t aware of most items in our industry,” he says. “Because people, in general, don’t like to be sold to, it’s important to have representatives for education and counseling rather than ‘sales associate.’ Having someone greet all customers, identify what their needs are and then respectfully guide them toward items they may not have been thinking about that will help with their unique situation is very important to the consumer.”

Francis says it’s also important to market a positive message of independence when marketing to seniors.

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“Seniors are simply getting older,” he says. “This does not make them automatically sick. They want items that will aid in their ability to live an independent life. Seniors, like everyone, respond to ‘free.’ Doing an in-store giveaway of a product or service is a great way to generate store traffic and a great way to generate leads.”

Ty Bello, President and Founder, Team@Work, says that when selling to seniors, remember that they are the experiential market segment. “What does that mean?” says Bello. “It means that this is the generation that made every shopping event and experience throughout their lives. We need to take a lesson from the big department stores and provide seniors with an experience. Starting with the way we greet them and not just let them wander throughout our store. Engage them, educate them, and sell them what they need and not what is on special.”

Flow is critical to the successful HME Provider who wants to have above-average cash sales. “Leave plenty of room between isles, do not overstuff your shelves,” says Bello. “This tends to look like a bargain basement store. Clear, large print signage throughout the store is important. Give them a tour, show them your store, even if they don’t need that product today, they may know someone who does or they might in the future. Just give them a tour and make them feel at home.”

Bello says to reach out to seniors by advertising in senior newspapers, senior villages and communities. He says that this is how they respond today, but this is an evolving generation and in several years most of the seniors served will get their news on-line.

VGM Retail, a division of VGM Group, says that seniors are more likely to buy products or services they have knowledge or recommendations to buy. Because most seniors are retired, they often spend time researching the best product for their specific needs. Carrying products specifically recommended or developed by local or well-known physicians or other clinicians or experts is a key sales strategy with this group. Partnering with your local hospital or medical groups to carry and market those products will add the extra trust factor this group looks for in its purchases.

Host seminars with those same experts to discuss specific disease states or trending healthcare and wellness habits and how the product can help make life better. In addition, you can set aside and advertise specific times when clinicians and experts will be in your store to demonstrate and answer questions about what products are needed for different disease states or wellness trends. Often clinicians and other experts looking for clients will work with you for free as they can generate clients leads for themselves and obtain exposure.

Provide plenty of research and data to seniors about your HME products, and present them with options for comparison. For example, install video monitors near the products placed on your sales floor. And work with the product manufacturers to run a video how-to or testimo-

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**Senior Retail Categories**

- Toe separators
- Gel toe spacers
- Diabetic gel socks

**Bath safety.** Slips and falls represent a tremendous risk for seniors, and the bathroom is usually the place in the home where this happens. There are a multiplicity of bath safety offerings that providers can offer to reduce this risk, ranging from grab bars, bathing chairs, non-slip surfaces, raised toilet seats, and hand-held showerheads to name a few. Because this is such a critical need, and these items are non-funded, this is a must-carry retail offering.

But don’t stop at the obvious items when considering your senior retail line-up. There are many out-of-the-box product ideas that provider might not necessarily think of, but that are hands-down retail winners. They leverage HME providers’ existing relationships with senior customers, product knowledge, and market understanding. All they require is a little new thinking and creativity to turn into retail business drivers. Let’s look at them:

**Senior Recreation.** This is another category that VGM Retail’s experts suggest that providers carry. While recreation might seem far afield from DME, it isn’t. What business is going to have a better idea of the sorts of exercise equipment, related health products and sports items that seniors are going to be able to find beneficial, use and enjoy than HME businesses? Some of these items include:

- Mini bike, arm exerciser and step machines
- Free weights
- Large print playing cards and card holder
- Large print brain games such as Sudoku or Crossword
- Body scales
- Fat loss monitors

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Follow Senior Retail Categories on Page 32
Money in the Bag

“People who expect to use a walking aid for longer distances or periods of time likely would prefer a version that includes a seat. Having the accessories readily available provides the senior with the opportunity to better understand how products might provide additional benefits.”

— Chris LaPorte, Personal Care Pro

Senior Retail Categories

- Basic and Advanced Courses
- Online Courses
- Webinars

Palmo loop on the product. The availability and accessibility of information will allow them to more easily make a decision when it comes to their purchasing needs.

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- Pain Management
- Hot and cold therapies
- Aromatherapy
- Lumbar support
- Gentle fitness
- Hand-held massagers

Power mobility. There are many senior customers who are more than willing to purchase power mobility items, such as scooters, on a retail basis. They might not have the funding for one, or they don’t like the scooter that their insurance will cover. In fact, retail power mobility has become such an important category, that manufactures now make a wide variety of retail power mobility offerings.

Respiratory. The same story is true for oxygen equipment. There are patients that want specific portable oxygen concentrators or home filling systems, and they have the means to pay for them on their own. While manufacturers of these systems have not responded to this retail need in the same way as mobility companies, there are patients more than willing to buy these systems despite the high price tag.

Best Sellers. Last but not least, there are some items that are tried-and-true winners that providers should always stock. Consider them the “impulse buys” of the home medical equipment world. The VGM Retail team says that best items to sell for seniors for an HME retailer should be connected or related to the reimbursable areas of specialty or expertise. However, there are impulse items that sell well in any environment with a high senior traffic population. Customers will pick up these items because it’s convenient.

- Readers
- Medical ID jewelry
- Healthy snacks and drinks
- Seasonal products: summer safety, light therapies
- Kits and bundled products: first aid kits, crutch, wheelchair and walker accessory kits

Joseph Duffy is a freelance writer and marketing consultant, and a regular contributor to HME Business and Respiratory & Sleep Management. He can be reached via e-mail at jduffy@hmemediagroup.com or joe@prooferati.com. HME Business editor David Kopf contributed to this story.

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For years — a decade, essentially — the industry has approached competitive bidding with one central strategy: it must be stopped. The program is bad for providers; it’s bad for patients; and it needs to be gone — period. Basically, the industry’s efforts to stop competitive bidding have revolved around the notion that we must stop the program and make it go away. With competitive bidding’s flaws, who wouldn’t agree?

There’s just one key problem with that strategy: it’s not working. This effort has included 2010’s H.R. 3790, the bill introduced by former Rep. Kendrick Meek (D-Fla.) that called for the repeal of competitive bidding; and the more recent H.R. 6490, the lapsed 2012 bill launched into the House by Rep. Tom Price (R-Ga.), that would have replaced CMS’s competitive bidding program with the industry’s Market Pricing Program (MPP).

Despite legions of co-sponsors, the Meek bill lapsed at the end of Meek’s term, and H.R. 6490 had hopes of being added to the “fiscal cliff” legislation (there were high hopes that might see passage given the crisis mindset of Capitol Hill at the time), but that eventually fell off the agenda. Both bills lapsed at the end of the 112th Congress.

And currently, we have H.R. 1717, which also would replace competitive bidding with the MPP. Rep. Price launched H.R. 1717 into the House in April last year with fellow House Ways and Means Committee member Rep. John Larson (D-Conn.). Dubbed the DMEPOS Market Pricing Program Act of 2013, the legislation quickly picked up solid backing. In less than two months, the bill was at 131 lawmakers signed on as co-sponsors.

But at a certain point — right about when Round Two reached implementation in July of 2013 — momentum on gaining co-sponsorships began to slow. It was steady, but not the flurry the bill enjoyed at the
Legislative Update

New Ideas

“The surety bond makes a whole lot of sense, and put some rationality into the program that doesn’t currently exist. It’s small, but it could have much more meaningful impact.”

— Cara Bachenheimer, Invacare Corp.

beginning. Today, more than a year later, the bill has been hovering at 180 co-sponsors, as some raise questions regarding how the bill would fare after the Congressional Budget Office scored it.

The upshot is that stopping competitive bidding outright might get signatures, but not enough political “push” for a vote. A strong argument that competitive bidding was seriously flawed was made by the industry, patients, and the more-than-200 economists (including five Nobel Laureates) organized by University of Maryland Professor of Economics Peter Cramton, the architect of the MPP, but at the end of the day, that has not been enough. Two lapsed bills and one bill that is creeping along are an indication that the strategy isn’t working.

The reason trying to stop competitive bidding outright hasn’t worked is thanks in large part to a highly partisan atmosphere. Congress has become dysfunctional, explains John Gallagher, vice president-govern-ment relations for HME member organization the VGM Group Inc. The House and Senate haven’t passed budgets like they should over the past eight years, and when Congress doesn’t pass bills and budgets, it loosens its oversight over federal agencies. This has let the Centers for Medicare and Medicaid services essentially “run amok,” he notes.

“CMS knows they’ll get a budget at the end of the year, and they do whatever they want to do,” Gallagher says. “… without Congress intervening.”

Interestingly, despite the fact that the country’s legislature has been paralyzed by political division, and the fact that the lower chamber is essentially controlled by the Republican party and the upper chamber under similar influence of the Democratic party, the industry can pull nearly 200 members of the House in bi-partisan support of the bill (47 percent Democrat; 53 percent Republican). Similarly, there was a bi-partisan letter circulated in the Senate and signed by 39 members (nearly split down the middle) that questioned CMS’s activity in compet-itive bidding. That proves the industry has political traction in Congress, which is the good news, it just needs to try a different way to use it.

Bearing all that in mind, the industry’s legislative leaders have a new plan; one that has resulted from a key strategy shift.

Fighting Smarter

That new idea is H.R. 4920, legislation that would make all bids binding as well as require providers to obtain bonds before bidding. Aiming to negate some of the most damaging elements of CMS’s competitive bidding program, Reps. Pat Tiberi (R-Ohio) and John Larson (D-Conn.) introduced the bill into the House in late June, dubbing it the Medicare DMEPOS Competitive Bidding Improvement Act of 2014.

The legislation would require that providers put up surety bonds — “biding bonds” — before submitting their bids to ensure those providers would truly bid an amount they could support. So, for example, if CMS offers a winning provider a contract and the provider declines to sign it, CMS can collect the bond. And when a provider wins a contract, the bid bond transfers to the performance bond that is already required.

“In essence, if you want to participate in a competitive bidding area, you will have to obtain a $50,000 bid bond from a bond company,” says Jay Witter, vice president of government affairs for the American Association for Homecare. “And if you are offered a contract either at or above your bid price, you will have to accept that contract, otherwise that bid bond is violated.

“Then, if you accept that contract,” he continues, “the bid bond turns into a performance bond, and you have you fulfill the elements of that contract. Otherwise, they [the bond issuers] can collect that $50,000 bond.”

Is $50,000 enough to a large company? Witter points out that if a company violates the bidding bond, the company then violates the surety bond already required by CMS for any and all companies to provide DME to Medicare beneficiaries.

“So there is an incentive, even for large companies, to comply with the bond and accept the contract they are offered,” Witter explains.

“It would absolutely do away with the speculative bidders, which we have in the market today,” adds Tom Ryan, president and CEO of the American Association for Homecare. “These people who have no expe-rience with the product, no experience with the demographic, put their toe in the water, and take up market capacity in an area for which they have no intent of serving.”

Does H.R. 4920 change problems in past rounds of competitive bidding? No. But it does set the stage to fix the program in re-competes going forward.

“It won’t change what’s happened now,” Gallagher says. “It won’t change the rollout competitive bidding nationwide in 2016, but with the re-compete Round Two, and the next re-compete of Round One, it would have an impact on those, with an intent of hopefully eliminating
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**Legislative Update**

**New Ideas**

“[H.R. 4920] won’t change the rollout competitive bidding nationwide in 2016, but with the re-compete Round Two, and the next re-compete of Round One, it would have an impact on those, with an intent of hopefully eliminating the suicide bids that were thrown out there.”

— John Gallagher, the VGM Group Inc.

industry champions who would love to see H.R. 1717 implement, but have determined that the bill is too complex, too large, and too hard to understand to be a viable legislative vehicle to move this year, given the political climate, says Seth Johnson, vice president of government affairs for Pride Mobility Products Corp.

“So, what we were asked to do by our industry champions, who believe that we need relief from ill-conceived competitive bidding program, if you could only have one or two provisions, what would they be?” Johnson explains. “We were advised that it has to be clear-cut, very straightforward, easy-to-understand, so that it is more viable and easier to get through the Congressional process prior to the start of the Round Two re-compete.

“We looked at the MPP, and what would be the biggest ‘nut’ that we could pull out of MPP to get some significant relief from the bidding program moving forward, if that’s all we could get,” he continues. “And it was pretty clear that the binding bid provision would be the provision that could do that.”

“We had to take it step-by-step,” Ryan said. “If there was one step we could take, this is it.”

Bachenheimer says working with Reps. Tiberi and Larson, what was driving them was the speculative bidding made by bidders that “came out of nowhere” and won contracts at the expense of established providers, Bachenheimer explains.

Moreover, it was clear those legislators did not want a piece of legis-

“[H.R. 4920] won’t change the rollout competitive bidding nationwide in 2016, but with the re-compete Round Two, and the next re-compete of Round One, it would have an impact on those, with an intent of hopefully eliminating the suicide bids that were thrown out there.”

— John Gallagher, the VGM Group Inc.

What About H.R. 1717?

Of course throughout this discussion, there’s still one lingering question: What about the MPP bill? H.R. 1717 is still active and slowly adding co-sponsors. Do providers continue to advocate and lobby on behalf of that bill, or do they pretend it doesn’t exist? How does the industry treat the legislation it has been backing?

Moreover, even CMS has said its hands were tied and that the ball is in Congress’ court.

“CMS has told folks on Capitol Hill repeatedly that they don’t have the statutory authority to make bids binding, and that Congress would have to authorize it,” Bachenheimer explains. “So this really responds to that.”

Getting H.R. 4920 Passed

So what will it take to get the binding bids bill passed? The push is to get as many co-sponsors passed as possible right before (as this article is going to press) and during the August recess for both the House and the Senate. This is important, because the 113th Congress has until the next election. Time is tight, but the bill’s limited scope and overall political neutrality give it a good chance, Johnson says.

Congress can put non-controversial bills on what is called the suspension calendar, according to Witter, and those can be voted very quickly through the process. Watchers of C-SPAN are probably familiar with the House voting through a large number of bills suspension of rules bills, usually on a Monday or Tuesday.

“So H.R. 4920 could move as a standalone piece of legislation,” Witter says. “With that said, you have to get the committees of jurisdiction to sign off. Well, that’s kind of already happened. Congressman Tiberi...
has gone to the Energy and Commerce Ways and Means committee chairs about this bill and got their sign-off. He’s also talked with Speaker Boehner from Ohio about this as well, and he was supportive of the process. So there is a distinct possibility this is going to be able to move on its own.”

“We’re being told that since the bill is bi-partisan and non-controversial that the likelihood of it being moved as a stand-alone piece of legislation and being voice voted is quite high,” he notes. “That’s a good position to be in given the challenges the calendar presents at this point in the process.”

This means getting co-sponsors for H.R. 4920, and again, moving H.R. 1717’s backers to move over should help that, which is handy, given the timing. How many co-sponsors? Experts agree that the binding bids bill needs to have around 200 co-sponsors signed on by the end of the August recess.

“This is going to be a piece of legislation that’s going to get lobbied hard during the August recess, period, in order to put us in the best possible position for advancement this year,” Johnson says.

And a stand-alone vote isn’t the only option, either. H.R. 4920 could get attached to larger legislation, as well.

“It could be attached to a larger vehicle later in the year,” Johnson says. “There’s a possibility that it could be attached to a Medicare vehicle after the elections, there’s appropriation bills that have to move through the process.”

“And again, there’s going to have be another SGR fix again, possibly in the lame duck session, I’m not sure,” Ryan says. “But the last one was only a short-term fix, so they have to go back at it again, and that would be another opportunity.”

But since the bill is so non-controversial that it could be voice voted as a standalone bill, that is the industry’s main strategy at the moment.

“That would certainly be the easiest to get this significant reform to the competitive bidding program put in place before the start of the Round Two re-compete begins next year,” Johnson explains.

Meanwhile work is being done to advance companion legislation in the Senate. At press time, the industry is still making headway in that regard, but there is hope that a sister bill will launch in the upper chamber by the time you read this article, before the August recess. The Senate has a process similar to the House’s suspension of rules called “unanimous consent,” and a similarly non-controversial Senate bill could just as easily move through such a process, according to Witter.

“We’re in the midst of working on a bi-partisan bill on the Senate side,” he says. “And hopefully it will be Senate Finance committee members.”

Time to Go to Work

Now, as Congress approaches recess, the industry has a new bill in
Legislative Update

New Ideas

“This system brings in private sector oversight. The private sector will be a second level of financial scrutiny. … They have a financial incentive ensure [bidders] are good companies and are going to fulfill the contract, otherwise they loose $50,000.”

— Jay Witter, American Association for Homecare

For HME business owners and operators wondering how to back the effort, Ryan says start by picking the low-hanging fruit, because gaining numbers fast counts more than ever with the binding bids bill.

“Look at your legislators, see who’s signed on to H.R. 1717, thank them for their support of that, and say that by signing on to H.R. 4920 they’re essentially singing on to what they’ve already supported, it’s just a more succinct fit,” Ryan says. “When you start to see that number of co-sponsors break 100 … that’s a good way to build momentum.”

At the end of the day, the binding bids bill is simultaneously not the best legislation the industry could ask for and is exactly the best legislation the industry could ask for. The bindings bids bill does not address all of the competitive bidding program’s many ills (and there are a lot of them), but it does address perhaps the most pivotal problem with the program. It doesn’t fix past inequities or restore business to providers who were unfairly nixed out of the market, but it helps return more fairness and more protection to the marketplace for the future.

Most of all, what the binding bids bill offers is a realistic chance for change, because it would work in today’s political and legislative climate. It is inherently neutral legislation that can pass as a standalone bill through a deeply divided legislature, and get signed into law. It might even be legislation that adds a requirement that CMS surreptitiously wishes had originally been part of the program. If anything, what H.R. 4920 offers the industry is the right bill for right now.

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■
As providers hunt for ways for expand their revenues, compression represents a key opportunity for HME businesses to serve new patients and drive new revenue. Compression can be used to treat a variety of conditions, including foot swelling, mild edema, varicose veins, thrombosis, varicosities of varying severities, and diabetes. This is where providers can help, by offering a range of compression solutions and ensuring staff can knowledgeably assist a wide range of patients.

Better yet, the revenue from compression products is usually cash sales and free from Medicare. There are only a few Medicare scenarios in which Medicare reimburses compression, so for the most part compression transactions are done a retail basis. And given the large number of diabetic patients, seniors and other major patient populations that need compression, the number of transactions can get very large. Providers that specialize in compression can often derive as much as a quarter of their revenues from compression garments alone.

That means that providers can concentrate on all the sales and marketing appeals that can drive increased sales. And sales and marketing is an important consideration because, at the end of the day compression garments are clothing, and that means that fashion can play a role. Compression or no, people want to feel what they’re wearing makes them look good. That opens a wealth of marketing opportunities for providers. Let’s look at some of the latest offerings on the market:

### Compression Product Solutions

**By David Kopf**

#### Cotton Sock for Men Comes in Range of Compression

**Dynamic Cotton Sock for Men**
- The Dynamic Cotton Sock for Men is opaque throughout from heel to calf.
- Offers a wider foot portion and features a prominent ribbed design.
- Available in 15-20 mmHg, 20-30 mmHg and 30-40 mmHg compression.
- Colors are brown, khaki, navy and black.

**Juzo**
(800) 222-4999
www.juzousa.com

#### Medical Surgical and Anti-Embolism Stockings

**Shape-to-Fit Compression Wear**
- Made from durable, breathable material, the stockings feature soft-seam construction and easy-on graduated compression, and are made for men and women.
- Anti-Embolism Collection stockings come with standard 18 mmHg compression and provide a massaging action to help prevent the formation of blood clots, protect against deep vein thrombosis, and improve circulation and valve function.
- Medical Surgical legwear feature an open-toe design provides graduated compression, helping to prevent the pooling of blood in the legs, as well as minor fatigue, aches and swelling.

**Dr. Comfort**
(877) 352-7833
www.drcomfort.com

#### Unisex Coolmax Socks

**UltiTher Ultimate Therapy Coolmax Sox**
- Designed for active patients, moisture wicking socks transfer moisture from the skin to the outside, therefore keeping the foot dry.
- Graduated 20-30 mmHg compression relieves tired, aching and swollen legs.
- Include soft rib knit with non-restricting band, reciprocated toe and heel, plush cushioned foot.
- Come in black and white and sizes Small, Medium, Large, X-Large.

**Global Health Connection Inc.**
(305) 289-9522
www.globalhealthconnectioninc.com

#### Fashion-Oriented Compression Knee High

**UltiTher Ultimate Therapy Microfiber Knee-High**
- Unisex knee high socks deliver medically correct graduated 20 -30 mmHg compression with fashion and comfort to help relieve pain of tired, aching legs, mild varicosities and edema, and are effective as post sclerotherapy treatment.
- Two-way stretch design, comfortable honeycomb knit top band, reciprocated toe and heel, flat seams on the open toe.
- Style includes open toe and closed toe knee high in black and beige, and sizes Small, Medium, Large, X-Large.

**Global Health Connection Inc.**
(305) 289-9522
www.globalhealthconnectioninc.com

#### Breathable and Comfortable

**SIGVARIS Sea Island Cotton Socks**
- Breathable and comfortable socks are made from rare cotton.
- Feature graduated compression of 15-20mmHg.
- Suitable for travel and daily wear. Available for both men and women in black, brown and navy.

**SIGVARIS Inc.**
(800) 322-7744
www.sigvarisusa.com

#### New Seasonal Colors

**2014 Summer Colors**
- Juzo Summer Colors include dolphin, mango, maize, pink, strawberry, orchid and midnight blue are available in compression knee-highs, thigh-highs, leggings, pantyhose, arm sleeves and gauntlets.
- All summer colors are available in the Soft and Dynamic product lines.
- Tie dye and black tie dye are available upon request.

**Juzo**
(800) 222-4999
www.juzousa.com
Turning, Transferring Positioning System
The Position Perfect System is a turning, transferring and positioning system that complies with facility turning protocols and protects patients from added pressure and shearing forces. Sold as a four-part system, the Position Perfect includes two foam, non-skid wedges, the WAFFLE Mattress Overlay, and the WAFFLE M.A.D. Hand Pump. Both wedges are constructed with non-skid material to help keep the wedge securely in place. The included, air-filled WAFFLE Mattress Overlay is made to go directly on top of an existing mattress to cradle the body, provide protection and treatment for pressure ulcers, and offer pain management. Dog-bone handwells also offer ease of use to the caregiver.

EHOB
www.ehob.com
(800) 899-5553

Device Combines Gait Training, Sit-to-Stand Transfers, Seated Transfers
The Rifton TRAM transfer and mobility device seamlessly performs seated transfers and raises a patient for standing and supported ambulation. Designed for the safety, convenience and dignity of both patient and caregiver, the TRAM combines three powerful functions in one device: gait training, sit-to-stand transfers, and seated transfers. A body support system eliminates any lifting by the caregiver, reducing back strain and workplace injuries. The TRAM has a 350lb. weight capacity and a powerful battery drive that can deliver over 70 lifts on a single charge. Weighing just over 70 lbs., the TRAM incorporates a compact, ultralight frame that is maneuverable in small or confined areas, and is simple to transport or store.

Rifton Equipment
www.rifton.com
(800) 571-8198

Combined Bariatric Commode and Shower Chair
Drive Medical’s new Bariatric Aluminum Rehab Shower and Commode Chair combines two necessary products in a single unit. The chair is constructed of rust-resistant, lightweight aluminum that is strong enough for users up to 500 lbs. Its 5 in. caster wheels allow it to easily move between bedroom and bathroom, and its easy push-button assembly means patients. The seat cut-out allows the chair to be positioned over a standard toilet, or the commode can be used anywhere with the included bucket. The backrest and seat are padded and the standard footrests are height and angle adjustable to ensure comfort. Accessories include biodegradable sanitary commode liners.

Drive Medical
www.drivemedical.com
(877) 224-0946

Reacher Locks Large and Small Items into Place
The Griploc Sliding Reacher integrates what maker HealthSmart calls PowerSlide technology to help the user securely grasp a range of items effortlessly, removing the need to apply an often-painful level of pressure to grip an object. The Twist and Click function lock objects securely into place and an extra-wide jaw and micro-grip tips ensure easy grasp of large and small items weighing up to 5 lbs. The Griploc Sliding Reacher has an MSRP of $39.99 and is currently available.

HealthSmart/Briggs Healthcare
www.griplocreacher.com
(800) 247-2343

Lift Chairs Add Hybrid Sizing to Improve Retail Appeal
To help providers maximize retail showroom space, the newest addition to Golden Technologies’ Cloud series of lift chairs, the PR-510-SME offers hybrid sizing as a small/medium chair designed to fit individuals from 5 foot 1 in. to 5 foot 6 in. tall and up to 375 lbs. The original Cloud lift chair, introduced in the fall of 2011, has been given a new model number: PR-510-MLA for medium/large, and is designed to fit people 5’7” to 6’4” up to 375 lbs. The Cloud models feature a wider biscuit backrest design; wider armrests for better support and a bucket seat design that cradles the lower body.

Golden Technologies
www.goldentech.com
(800) 624-6374

Bariatric Rollator Offers Large Wheels, Supports 500 Lbs.
If patients need a rollator to improve daily mobility, but they require heavy duty strength and durability, the Bariatric Rollator from Drive offers 7.5 in. wheels and a 500 lb. weight capacity. Complementing the rollator’s increased weight capacity, the Bariatric Rollator providers extra-wide distance between the handles in order to provide more comfortable use. The 7.5 in. wheels make it great for both indoors and outdoors, and a large, padded seat provides a comfortable resting spot when you’re on the go. The Bariatric Rollator also includes a secure carry pouch to let patients carry items with them.

Drive Medical
www.drivemedical.com
(877) 224-0946
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### Upcoming Industry Events

#### August 2014

- **Aug 4-6**
  - Arizona Society for Respiratory Care Annual Conference
    - [Website](http://azsrc.org)

- **Aug 13-15**
  - Big Sky Ames Annual Convention
    - [Website](http://bigskynamess.org)

- **Aug 14**
  - AZMESA Conference
    - [Website](http://arizonamesa.org)

- **Aug 15**
  - Annual Indiana Society of Sleep Professionals (ISSP) Sleep Summit
    - [Website](http://indianasleep.com/)

#### September 2014

- **Sep 10**
  - OAMES Medicaid Training Seminar
    - [Website](http://oames.org)

- **Sep 16-17**
  - South Dakota Society for Respiratory Care Annual Meeting & Conference
    - [Website](http://sdsrc.org)

- **Sep 18-19**
  - Wyoming Society for Respiratory Care State Conference
    - [Website](http://wsrsc.org)

- **Sep 20-21**
  - Texas Association for Home Care & Hospice Annual Meeting
    - [Website](http://tahch.org)

- **Sep 24**
  - CAMES Annual Meeting
    - [Website](http://cameas.org)

- **Sep 27**
  - Minnesota Sleep Society Annual Education Meeting
    - [Website](http://mssleep.org)

- **Sep 29-30**
  - Michigan Society for Respiratory Care Fall Conference
    - [Website](http://michiganrc.org)
How can providers measure their quality to attract patients and referral partners?

While in California recently I took part in a conference that focused on healthcare provider quality issues. During one session, the classic 1992 movie “A Few Good Men” was mentioned.

Being a courtroom drama buff as well as having a daughter and son-in-law in the military who have been in harms way more times than I’ll ever know, the film has become one of my all time favorites to the point that I’ve memorized much of the dialogue. Since quality claims were the topic of discussion, I’ve paraphrased a line that Tom Cruise’s character, (Lt. Daniel Kaffee, USN) came to mind: “It doesn’t matter what you believe, only what you can prove!”

Admittedly, a fictional military courtroom drama is a far cry from today’s hyper-competitive DME marketplace. However, one can readily see how Lt. Kaffee’s declaration takes on a certain relevance when you consider how HME providers tout the greatness of their products and service while aiming their marketing messages at payors, referral sources and potential customers and patients.

There’s no doubt that they fervently believe what they are saying, but can they prove it? As the President of a “deemed” DMEPOS accreditation organization (AO), it should not come as a surprise to anyone when I say that meeting a Medicare AO’s quality standards will go a long way in substantiating the veracity of your quality claims. However, just stating that you are accredited may not be enough “proof” in this day and age of heightened scrutiny from the government, managed care, journalists, and ever more skeptical patient advocate groups.

So how does a DME provider go about substantiating their quality claims? As I see it, in addition to embracing the benefits of accreditation as a helpful quality improvement process, it’s equally important that HME providers tout the operational strengths and uniqueness of their business model, and back it up with evidence that can be used to differentiate themselves. Your day-to-day operations can supply you with powerful information that can and should be shared with payers, referrals and customers.

Referral Source

As a business owner you know your strengths and weaknesses better than anyone. First, you need to identify the features and benefits of your products and services so you can tailor your approach to meet the expectations of specific referral sources. Given the diversity of providers, here is a snap shot of how common providers types can market their businesses through quality measurement:

Complex rehab: Take a complex rehab business, for instance. It’s likely that your referral sources would be interested in your staff’s credentials and whether they are qualified in evaluation, measurement and fitting. Note that these are also mandatory accreditation requirements. It would also be very helpful if you show how you track delivery response times. Here are some specific ways to do that:

- Time from order to initial assessment.
- Delivery time for custom and non-custom products.
- Quality control data that supports initial measurements matched to product.
- Patient data supporting comfort and fit of the product received and outcome.
- Follow-up policy (e.g., The time frame you contact patient after delivery).
- Share how you document via a sample patient packet that includes a plan of care, measurement forms for product, product specs and a follow-up form.
- How a patient is contacted in case of malfunction.

Respiratory: In the respiratory sector of DME, it is vitally important to communicate to your referral sources that they will have 24-hour/ seven-day access to your services. Response time in delivering oxygen to a patient is often a deciding factor in getting a hospital discharge planner to choose one oxygen provider over another; providing of course you have either won the competitive bid in your area or your are outside bidding area.

Payors

The Affordable Care Act (ACA) mandates that as of January 1, 2015, managed care and third party payers need to base provider fee schedules on value, not volume. A provision in the Act ties physician and provider payments to the quality of care rendered; not just that a service was performed. Physicians and other provider organizations will see their payments modified so that those who demonstrate better care will receive higher payments.

In terms of Medicare Advantage plans, the Centers for Medicare and Medicaid Services (CMS) strengthened the ACA “five-star” plan bonus system with a demonstration that accelerates and increases the incentives for improvement in the quality of care provided to nearly 13 million beneficiaries. True, DME’s are only ancillary provider to Medicare Advantage Networks, but all DME businesses are driven by a doctor’s orders. So if physicians are being held accountable, so will all of their ancillary providers (that’s you) in terms of products or services offered, area served, quality, and price. Physician will choose the best option for their patient.

Equipment and Patients

Demonstrate your products’ superiority and ability to serve specialized needs. Also, present data on the percentage of breakdowns, because fewer breakdowns translate to fewer repairs and less inconvenience to patients. Show how long it takes to fix or replace a product when repairs are needed, and whether or not you repair on-site for quick turn around? (Those are selling points.)

For patients, documentation is your most powerful tool. When giving patient and caregiver instruction, track data on patient/caregiver understanding, data on re-visit after instruction; and low to no patient incident on equipment. Survey patient satisfaction, and track data on patient outcomes.

Proving Quality

Communicate your benefit by displaying your Certificate of Accreditation. Share satisfaction survey results with your customers and patients. Post all in places where they will see it (e.g., website, office, retail space). Communicate to your client how you are going to meet their needs, such as evaluating their needs personally; instruction by competent caring staff; instructions via website and brochures. Also, ask your current customers why they chose you to be their provider. What do they like about your business? Ask them how you can improve. Its all about continuous improvement.

Now I admit that the above evidence gathering tips may not be as sexy as a Hollywood courtroom drama, but they will undoubtedly help you present the proof that will help you win your case.

Sandra Canally, RN, BS, is founder and president of accreditation organization The Compliance Team Inc. (Spring House, Pa.; www.thecompliance-team.org). She can be reached at scanally@TheComplianceTeam.org.

Management Solutions | Technology | Products
The Stand Up for Homecare reception at Medtrade is the premier networking event for the homecare industry. When you Stand Up for Homecare, you are endorsing AAHomecare efforts to promote a positive image of the home medical equipment industry, raise public awareness of homecare’s many benefits, and support consumer advocacy groups out there making a difference in patient’s lives. It’s time for us all to stand together and support our industry, and have fun doing it!

AAHomecare.org/advocacy/stand-up-for-homecare

Atlanta, GA
October 21
6:00pm
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